Complaint No: _____ Date Received: _____

KENTUCKY BOARD OF LICENSURE OF MARRIAGE AND FAMILY THERAPISTS
Complaint Form

Person Filing Complaint

Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Day Telephone: _____ Evening Phone: _____

Client Information
(If Applicable)

Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Day Telephone: _____ Evening Phone: _____

Relationship to person filing complaint: _____

Name of Therapist

Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Day Telephone: _____

Name and phone number of persons who may provide additional information

1. Name: _____ Telephone: _____ Type of Information: _____
2. Name: _____ Telephone: _____ Type of Information: _____
3. Name: _____ Telephone: _____ Type of Information: _____
4. Name: _____ Telephone: _____ Type of Information: _____

Brief Summary of Complaint

(Please be specific as possible regarding names, dates, locations, and action which you believe to be improper, unethical or unprofessional. Please attach copies of any documents or records pertinent to your complaint.)

By signing this complaint form, I hereby certify that the information is complete and true to the best of my knowledge.

Signature: _____ Date: _____

If your complaint concerns your treatment by the therapist, please sign and enclose the "Client Agreement to Release Information" form.

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Send to: **KENTUCKY BOARD OF LICENSURE OF MARRIAGE AND FAMILY THERAPISTS**
PO BOX 1360
FRANKFORT, KY 40601

Phone: (502)564-3296
Fax: (502)564-4818

Authorization for Release of Medical and Client Records to the Kentucky Board of Licensure of Marriage and Family Therapists

I, _____ , the undersigned, do hereby authorize the full
(Print Name Here)
release of any and all medical and psychological records, billing information, and medical and psychological reports from

_____, _____ Licensed Marriage and Family Therapist, regarding

the medical and psychological history, diagnosis, and treatment of me while a patient of the therapist to the Kentucky Board of Licensure of Marriage and Family Therapists or any authorized agent or investigator of the Board.

I understand that the above records may be used by the Board I the investigation and possible disciplinary prosecution under KRS Chapter 335 against the therapist. I further understand that the Board will make reasonable efforts to protect the confidentiality of my records under KRS Chapter 61 and KRS Chapter 13B, or other applicable law.

A photocopy of this authorization shall be deemed as an original.

This authorization shall be effective for one year from the state of signing.

_____ _____

Date

Signature of patient, or parent/legal guardian of patient is under 18 years of age.